U. S. No. 2
10M—2-43
5-17-39
I X3582

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

17019
State File No.

FILED JUN 7 1943
Registration District No. 1149
Primary Registration District No. 1002
Registrar's No. 2307

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
In this community unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 916 Holmes 8
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Julius Lauer
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex male
5. Color or race White
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 9 (Day) 1873 (Year)

8. AGE: Years	Months	Days	If less than one day
70	10	9	hr. min.

9. Birthplace (City, town or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER
12. Name William Lauer
13. Birthplace (City, town or county) Mo (State or foreign country)
FATHER
14. Maiden name Katie Bunkie
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Next Clerk
(b) Address KC Gen Hospital
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/20/43 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem KC Kans
18. (a) Signature of funeral director Lebleto
(b) Address 901 E 9th St
19. (a) 5/19/43 (Date received local registrar) (b) M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1943 hour 5 minute 15 A. M.
21. I hereby certify that I attended the deceased from May 9, 1943 to May 18, 1943 that I last saw him alive on May 18, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
acute cardiac failure	
Due to Prostatic hypertrophy	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Dudley R. Thorne (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ✓ ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Roy C Snow

Licensed Embalmer No. 2560

P. O. Address Kb Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.